

DOCTOR _____

SURNAME _____ NAME _____

ADDRESS _____

PHONE _____ E-MAIL _____

CONSENT FORM FOR NCTF® AND M-HA®

Please read and complete this consent form, making certain that you understand all the information provided and that you agree to and understand the treatment program.

THIS DOCUMENT HAS BEEN GIVEN TO:

SURNAME: NAME:

DATE OF BIRTH: / /

ADDRESS:

PHONE: E-MAIL:

I have been informed that:

the micro-needling / multi-injection biorevitalization treatment is designed to improve skin quality but not perfect it. I understand that results differ from person to person and personal maintenance between sessions is important. It is delivered by a series of superficial injections and multipunctures.

The use, indications, contraindications and potential adverse effects of the treatment with NCTF® and M-HA® have been explained to me. I have answered all the questions in a medical questionnaire, truthfully with regard to my medical and aesthetic history. I have declared any known allergies or potential contraindications. I was able to ask all the questions I wanted and was given satisfactory answers. My practitioner has given me information regarding complications, potential side effects and pre and post treatment cares.

I,, understand that possible side effects are;

- Redness or mild local inflammation can occur after the treatment but usually disappears within some days.
- Mild edema and small ecchymosis (bruising) may occur, but disappear within 48 hours.
- Minimal bleeding at the injection / puncture site can occur and stops rapidly and spontaneously after the injection.
- Transient pain at the injection site is possible.

These reactions can persist for one week; reactions occurring beyond that or the late onset of any other adverse events must be reported to your practitioner or family doctor as soon as possible.

I, the undersigned, declare that I have been made aware of and perfectly understand the information provided to me about micro-needling / multi-injection biorevitalization treatment administered for aesthetic purposes. I give permission to the practitioner, expressly without any reservations, after taking time for reflection, to carry out the treatment. I have read and understood the instructions for pre and post cares and consent to undergo the procedure.

PATIENT

Print name:
Date: / /

Signature
(preceded by the mention "read, understood and approved")

PRACTITIONER

Date: / /

Signature